Palliative Care in the ED: Don’t Just Do Something...Stand There

Eric Isaacs, MD, FACEP
Attending Physician, San Francisco General Hospital and Trauma Center
Professor of Emergency Medicine, University of California, San Francisco
Eric.Isaacs@emergency.ucsf.edu

Objectives:
• Understand how to integrate Palliative Care into the emergency department
• Differentiate the needs of Palliative Care patients from other ED patients.
• Discuss the benefits of a Palliative Care approach to selected ED patients.

ACEP: Choosing Wisely Campaign
• Don’t delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.
• Palliative care provides comfort and relief of symptoms for patients with chronic and/or incurable diseases.
• Hospice care is palliative care for those patients in the final few months of life.
• Engage patients chronic or terminal illnesses and their families, in conversations about palliative and hospice services.
• Early referral from the ED to hospice and palliative care services benefits select patients resulting in both improved quality and quantity of life.

Palliative Care program involving the ED?
When you hear “Palliative Care in the ED,” do you feel:

1) Nervous?
2) This will be too difficult?
3) I am motivated to incorporate this?
4) All of the above

Tension Points...

- Bias towards action
- The Facts (or the lack thereof)
- Emotional Issues
- Communication Issues

Reality Check: Provide Excellent Care

- Triage and disposition
  - Right care, right place, in a timely manner
- Optimizing and efficiently using ED resources
  - Reducing ED length of stay
  - Increasing ED throughput
  - Decreasing ED boarding of admitted patients
- Increasing patient/family satisfaction

Reality Check: Provide Excellent Care

- Triage and disposition
  - Right care, right place, in a timely manner
- Optimizing and efficiently using ED resources
  - Reducing ED length of stay
  - Increasing ED throughput
  - Decreasing ED boarding of admitted patients
- Increasing patient/family satisfaction
- Palliative Care can address all of these!
How Many of you would like to die from:

1) Sudden death
2) Terminal illness
3) Organ failure
4) Frailty

Global trajectories:
How Many of you would like to die from:

- Sudden death (6%)
- Terminal illness
- Organ failure
- Frailty

- 80% want to die at home
- 17% die at home. 60% in hospitals and 20% SNF

Case # 1: Yellow? Anyone home?

- 56 year old male with a history of pancreatic cancer
- Brought in by his wife due to shortness of breath and fatigue
- He has a chemotherapy appointment on Tuesday and they want to get him tuned up a bit so he can get his next dose of chemo
Case # 1: Yellow? Anyone home?

- Vital Signs: Temp 38.6 (oral), P. 110, BP 92/48, RR 24
- As you walk into the room,
  - Patient is severely jaundiced
  - Abdomen very distended with ascites
  - Looks in mild respiratory distress
- There are no beds; it will be 3 hours...

Your Thoughts...?

- A-B-C  IV-O2-Monitor
- “WHY did she bring him to the ED?”
- “Just get him upstairs”
- “%$#@!! Oncologists”
- “We have some talking to do...”

Your Thoughts...?

- A-B-C  IV-O2-Monitor
- “WHY did she bring him to the ED?”
- “Just get him upstairs”
- “%$#@!! Oncologists”
- “We have some talking to do...”
Your Thoughts…?

- A-B-C  IV-O2-Monitor
- “WHY did she bring him to the ED?”
- “Just get him upstairs”
- “%$#@!! Oncologists”
- “We have some talking to do…”
- Palliative Care in the ED

What is Palliative Care?

- Intends neither to hasten or postpone death
- Patient determined goals of care
- Relief of pain and other distressing symptoms
  - Includes psychological and spiritual
- Involves patients and families
- Support an understanding of disease process

Models of Palliative Care

- Palliative Care consultant comes to the ED
- Palliative Care consultant will see the patient upstairs
  - Referred by ED
  - Referred by Hospitalist
- No Palliative Care consultant: Emergency Physician responsible for trajectory of care in the hospital.
- Emergency Physician required to trigger all of these

Palliative Care “Integration” in the Emergency Department

- Just like Toxicology...
- Incorporate palliative care principles into daily practice
  - Dedicated hospital palliative care team or inpatient palliative care unit NOT REQUIRED
- We are doing “Palliative Care” every day
  - Non-curative symptom management
  - Thinking about trajectories
  - Delivering bad news
Models of palliative care

Old

Life prolonging care

Hospice Benefit

Disease progression

New

Life prolonging care

Hospice Care

Palliative care

Diagnosis of serious illness

Death

Palliative Care in the E.D.: We are missing Patients who need:

- Improved communication skills around goals of care
- More attention on assessment/documentation of pain and other symptoms
- Emphasis on symptom interventions with improved EOL outcomes

Palliative Care is like Hypertension...

- Routine Follow-up: Do they have a serious or incurable illness?
  - Print information
  - Referral for services
- Urgency (Would you be surprised if they died in the next 6 months?)
  - Follow up in one week
- Emergency (Would you be surprised if they died during this admission?)
  - Rapid palliative care assessment
  - ED based palliative care/hospice consult

Who Do We Screen?

- Serious or life-threatening illness and one or more:
  - Not Surprised
    - If the patient died in next 12 months
  - Bounce-Back
    - More than one ED visit or admit for same condition in last few months
  - Uncontrolled Symptoms
    - ED visit prompted by difficulty to control physical or psychological symptoms
  - Functional Decline
    - Decline in function, feeding, weight loss, or caregiver distress
  - Increasingly Complicated
    - Long-term care needs requiring more resources or support
Who to include:

- The less obvious but obvious
- Dialysis Patients
  - Nearly 25% per year
  - Mortality for a 40 year old
    - (8.4 vs. 37 years)
- COPD (Third leading cause of death in US)
- CHF (NYH Class 4 - 1 yr mortality=50-66%)

Who to Include: Hospice Eligible
(>50% chance dying in next 6 months)

- Progressive disease
  - Increased symptoms, worsening lab values or functional status and/or evidence of metastatic disease, particularly brain
- Weight loss >5% in last 3 months
- Karnofsky Performance Scale or PPS< 70%

Palliative performance scale

<table>
<thead>
<tr>
<th>Percent Activity</th>
<th>Ambulation</th>
<th>Activity</th>
<th>Self-Care</th>
<th>Intake</th>
<th>LOC</th>
<th>Estimated Median Survival (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>Reduced</td>
<td>No Job</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
<td>108-145</td>
</tr>
<tr>
<td>40</td>
<td>Mainly bed</td>
<td>No Job</td>
<td>No housework</td>
<td>Occasional Assistance</td>
<td>Normal or reduced</td>
<td>Full or drowsy</td>
</tr>
<tr>
<td>10</td>
<td>Bed bound</td>
<td>No Job</td>
<td>No housework</td>
<td>Significant Assistance</td>
<td>Mouth care only</td>
<td>Drowsy/coma</td>
</tr>
</tbody>
</table>

Hospice

- Hospice has greatest patient/family satisfaction: Process not a place
  - Protocol driven medications, equipment, support of physical, psychosocial and spiritual needs.
- Some departments can refer directly to hospice
  - Need a lot of support
What if the Intervention Began EARLIER than the ICU?

<table>
<thead>
<tr>
<th>Costs</th>
<th>Usual Care</th>
<th>Palliative Care</th>
<th>∆</th>
<th>Usual Care</th>
<th>Palliative Care</th>
<th>∆</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Day</td>
<td>$830</td>
<td>$666</td>
<td>$174*</td>
<td>$1,484</td>
<td>$1,110</td>
<td>$374*</td>
</tr>
<tr>
<td>Per Admission</td>
<td>$11,140</td>
<td>$9,445</td>
<td>$1,696***</td>
<td>$22,674</td>
<td>$17,765</td>
<td>$4,908**</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$1,227</td>
<td>$803</td>
<td>$424*</td>
<td>$2,765</td>
<td>$1,838</td>
<td>$926*</td>
</tr>
<tr>
<td>ICU</td>
<td>$7,096</td>
<td>$1,917</td>
<td>$5,178*</td>
<td>$14,542</td>
<td>$7,929</td>
<td>$7,776*</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$2,190</td>
<td>$2,001</td>
<td>$190</td>
<td>$5,625</td>
<td>$4,081</td>
<td>$1,544***</td>
</tr>
<tr>
<td>Imaging</td>
<td>$890</td>
<td>$949</td>
<td>($58)***</td>
<td>$1,673</td>
<td>$1,540</td>
<td>$133</td>
</tr>
<tr>
<td>Died in ICU</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>18%</td>
<td>4%</td>
<td>14%*</td>
</tr>
</tbody>
</table>

Goals of Care/Code Discussion

- **Who to include?**
  - Gestalt...you are better than you think
  - We are really good at sick or not sick
  - The better you know the patient, the worse you are at predicting prognosis
    - (Too Optimistic)
  - Plan for the worst...hope for the best

Assessment choice

- Patient condition drives assessment

**ABCD Assessment**

- **Advance care plan**
- Make the patient feel Better
- **Caregivers to consider**
- Decision-making capacity

- Covers physical, psychosocial domains
- If patient stabilizes, move onto sub-acute assessment
Case # 1: Yellow? Anyone home?

Triage/Bedsides Assessment
- Serious/Terminal Illness
- Unstable/Critical (e.g. near arrest, VS compromised)
- Focused Assessment ‘ABCD’
- Expanded Assessment ‘NEST’

Stable

Advance Care Plan: No details. No compressions.
- Doesn’t believe he can be cured, but wants to squeeze out a bit more time.

Better: Oxygen, Fluid, Antibiotics, consider paracentesis

Caregivers: “I need you to do everything; I don’t know what I am going to do without him”

Decision-Making Capacity: understand and process information, articulate a decision, consistent values

NEST
- N: social NEEDS guide post-ED disposition and prevent repeat visits?
- E: EXISTENTIAL needs: Distress, Settledness, Faith, Wishes, Unfinished business
- S: SYMPTOMS: (physical or psychological) require treatment during this visit?
- T: THERAPEUTIC goals be for this ED visit or hospitalization?

What is a good goals/code discussion?

Getting the “DNR”
What is a good goals/code discussion?

- Patient is expert in own values and goals
- Our expertise is treatment, procedures and their indications
- Our job is to match procedures to their values and goals

6 (+1) Goals/Code Discussion Items:
- Understanding of your illness
- Information preferences
- Fears and worries
- Goals (if time is short)
- Trade-offs (to achieve your goals)
- Unacceptable states
- Recommend and listen for response
6 (+1) Goals/Code Discussion Items:
- Understanding (U-You)
- Information (I-I)
- Fears (F-Feel)
- Goals (G-Good)
- Trade-offs (T-Talking)
- Unacceptable (U-Ultimate)
- Recommend (R-Responsibility)

Case # 1: Yellow? Anyone home?
- Understanding: Terminal; obstructing bile
- Information: Engineer; likes details
- Fears: Wife will be lonely and kids last memory.
- Goals: Make it to Thanksgiving
- Trade-offs: Painful procedures
- Unacceptable states: A drain on family and unable to communicate
- Recommend and listen for response
- Make a plan…

Principles of Communication
- Undivided attention
- Address patient’s agenda
- Track emotion and cognitive data
- Move conversation one step at a time
- Articulate empathy explicitly
- Focus on what we CAN do
- Big picture goals before talking interventions

Tips for Success:
- Open ended questions…”Tell me more about that”
- “How much time do I have?”
- “Tell me why you are asking”
- If negative emotions, stop & change direction
- Goals and Tradeoffs: “What is your unfinished business?”
- Don’t be afraid to use words death or dying
- Pay attention when someone says “Good job”
- Debrief/Solicit feedback
Pitfalls

- “There is nothing we can do”
- “Everything is going to be ok”
- “Should we do everything?”

- No need for a menu

Conclusion

- Integrate PC into your daily practice
- Many missed patients with unmet needs needing Palliative Care
  - Do an assessment on those who may die in the next 12 months.
    - Like Hypertension: Emergency/Urgency/routine
- Focus on goals not menu items
- Communication strategies

Resources:

- Fast Facts:
  - www.eperc.mcw.edu/EPERC/FastFactsandConcepts
- Center to Advance Palliative Care:
  - www.capc.org
- EPEC-EM: Education in Palliative and End-of-life Care
  - www.epec.net/epec_em.php
- Opioids App
- ePrognosis
- Hospice in a Minute

Questions?

- Eric.Isaacs@emergency.ucsf.edu